MDR Tracking Number: M5-04-0262-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received September 23, 2003.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity for Hydrocodone with APAP, carisoprodol (Soma), and Bio-freeze. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The respondent raised no other reasons for denying reimbursement Hydrocodone with APAP, carisoprodol (Soma), and Bio-freeze

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 10-28-02 through 03-17-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 10th day of December 2003.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

GR/gr

NOTICE OF INDEPENDENT REVIEW DECISION

December 4, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-0262-01
IRO Certificate #: IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in neurosurgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient sustained an injury on ___ when the chair she was on rolled back, causing her to fall and land on her buttocks. She immediately reported low back pain, which radiated down left lower extremities. The patient was prescribed muscle relaxant, anti-inflammatory, and pain medications.

Requested Service(s)
Prescription medications hydrocodone with APAP, carisoprodol (Soma), and Bio-freeze from 10/28/02 through 03/17/03.

Decision
It is determined that the prescription medications hydrocodone with APAP, carisoprodol (Soma), and Bio-freeze from 10/28/02 through 03/17/03 were medically necessary to treat this patient’s condition.

Rationale/Basis for Decision
The medications in question, hydrocodone, carisoprodol, and Biofreeze, are all appropriate, indicated, and well accepted for use in such clinical situations. There is no indication of abuse and the medical record does indicate that the clinician is of the opinion that the medication regimen is benefiting the patient. Therefore, it is determined that the prescription medications hydrocodone with APAP, carisoprodol (Soma), and Bio-freeze from 10/28/02 through 03/17/03 were medically necessary.

Sincerely,